

IF YOU HAVE ANY QUESTIONS ABOUT DISABILITY BENEFITS OR YOUR INSURANCE,
PLEASE CALL OUR TOLL FREE NUMBER 1-800-669-8477

13. HOSPITALS WHERE YOU HAVE BEEN TREATED, INCLUDING VA HOSPITALS

NAME OF HOSPITAL	ADDRESS OF HOSPITAL	DATE OF ADMISSION	DATE OF RELEASE

14. PHYSICIANS WHO HAVE TREATED YOU FOR DISEASE OR INJURY, CAUSING TOTAL PERMANENT DISABILITY

NAME OF PHYSICIAN	ADDRESS OF PHYSICIAN	DATE TREATMENT BEGAN	DATE OF LAST TREATMENT

15. RECORD OF EMPLOYMENT FOR ONE YEAR PRIOR TO THE DATE OF TOTAL DISABILITY TO THE PRESENT
(Include self-employment)

DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WORKED	EARNINGS
FROM	TO	DATE	WEEKLY	WEEKLY
OCCUPATION		NAME AND ADDRESS OF EMPLOYER		REASON FOR TERMINATION OF EMPLOYMENT
DATES OF EMPLOYMENT		LAST DAY INSURED WORKED	HOURS WORKED	EARNINGS
FROM	TO	DATE	WEEKLY	WEEKLY
OCCUPATION		NAME AND ADDRESS OF EMPLOYER		REASON FOR TERMINATION OF EMPLOYMENT

I consent that any physician or hospital who has treated or examined me for any purpose, or who I have consulted professionally, any insurance company or organization to which I have applied for insurance, or any person, persons, firm or corporation to whom, or to which I have applied for employment or disability benefits, may provide to the Department of Veterans Affairs or testify as to, or produce in court, any information obtained concerning myself by reason of the foregoing, and waive any privileges which render such information confidential.

A photostatic copy of this consent shall be considered valid authorization for release of information to VA.

I certify that each question has been truthfully and completely answered to the best of my knowledge.

16. DATE OF SIGNATURE	17. SIGNATURE OF INSURED (Or official or fiduciary completing form for insured)

PENALTY - The law provides that whoever makes any statement of a material fact, knowing it to be false, shall be punished by fine or imprisonment or both.